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ABSTRACT

Families First, an early intervention program implemented in Marin City, California, was designed to integrate and coordinate the provision of a wide range of services to families of children in a low-income, mostly African-American community, from the third trimester of pregnancy to 8 years of age. The program is intended to enhance the children's intellectual, social, emotional, and physical development. This handbook includes two types of information related to Families First: (1) a description of the two-pronged, augmented family support system used in the program; and (2) recommendations for the functioning of case management and family support services. The handbook's focus is the day-to-day work of family advocates and their clinical coordinator in a program designed to deal with the problems and risks of living in a low-income, high drug community. Information is presented about recommended operating principals, staffing patterns, orientation and training plans, and program operations. Common problems of this type of work are pointed out, and uncommon conditions of families are documented. The handbook also contains recommended approach styles with these families and advice on recruitment, the development of relationships, dealing with crises, and sustaining relationships with families. (AA)

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A Case Management and Family Support Handbook

Lessons Learned from the Development and Implementation of Marin City Families First an Early Intervention Program

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Far West Laboratory for Educational Research and Development
730 Harrison Street, San Francisco, CA 94107-1242 (415) 565-3000

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A Case Management and Family Support Handbook

Lessons Learned from the Development and Implementation of Marin City Families First an Early Intervention Program

J. Ronald Lally, Ed.D.
Douglas Quiett, M.S.W.
Center for Child and Family Studies
Far West Laboratory for Educational Research and Development

Anne Coelho, M.R.E.
Susie Bailey, Director
Operation Give a Damn

November 30, 1993

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Executive Summary

This handbook is written for those who are currently operating or anticipating operating a community based family support system in a low income community. Its suggestions and recommendations are drawn from the Far West Laboratory experiences of designing and assisting in the day to day operation of one such program. This particular program, **Marin City Families First**, begins services to families during the time when a Marin City mother is pregnant and continues services until that program child reaches grade three. The handbook contains two types of information: 1) a description of the two pronged augmented family support system used in the program, and 2) recommendations, for day to day functioning of case management and family support services. The document primary emphasis is on describing appropriate selection, preparation, and practice for the case management and family support services.

The focus of this document is the day to day work of family advocates and their clinical coordinator in a program designed to help families and community agencies deal with the problems and risks of living in a low-income and high drug use community. Information is presented about recommended operating principal, staffing patterns, orientation and training plans, and program operations. Much of the document contains case material on the day to day provision of family support from the point of view of the family advocates and clinical coordinator providing the services. Common problems of this type of work are pointed out and uncommon conditions of families are documented. Much of the document contains information about the difficult life of families in a low-income high drug use community. It also contains recommended approach styles with these families, and advice on recruitment, the development of relationships with program families, dealing with crisis, and sustaining relationships with families. The information presented deals with start up and initial service efforts. **Marin City Families First**, although a long time in conceptualization, planning, and in developing collaborative agreements and strategies with community agencies is only in its' eighth month of weekly service to program families.

I. Introduction

The first of the National Education Goals, "by the year 2000, all children in America will start school ready to learn," reflects the importance of early experience in the long-range development and success of children. Yet as we approach the year 2000, the American family with young children functions in a pressure cooker. These families are routinely juggling the demands of home and workplace and burdened by financial worry. Most parents with young children experience conflict and confusion about their roles at home and at work, and feelings of guilt about neglecting children. These issues are exacerbated by the erosion of traditional family supports, divorce, and a lack of reliable and affordable child care. Although all families need support, some families are in desperate need of support. Substance abuse and violence in many communities have reached a crisis level. High risk pregnancies have increased dramatically, and more families with young children than ever before are living in poverty.

Many communities are dealing with the overwhelming issues of high unemployment, drug use, violence, racial prejudice, and family disintegration. Yet gaps in service, inadequate funding, lack of coordination among service providers, insufficient training, and crisis management seriously impede the development and implementation of critically needed services. These communities need information about appropriate intervention strategies and guidance on how to develop a collaborative family, education, and social service structure.

For the past five years Far West Laboratory (FWL), through its Bay Area Early Intervention Program, has worked with local community agencies in Oakland, San Francisco, and Marin City, California, to develop a two pronged community intervention model. This model, Augmented Family Support Systems, is now being implemented in the low-income, mostly African-American community of Marin City, California. Starting in January of 1993 **Marin City Families First** (hereafter referred to as MCFF) came into existence with joint funding from the Office of Educational Research and Improvement, and the Stuart Foundations. The program's goal is to develop comprehensive, community-based services for low-income children and their families starting during pregnancy and continuing until program children reach age eight.

MCFF is a research and development effort working with families, community agencies, and schools. Three documents have been created that explain the approach : Augmented Family Support Systems : A Description of An Early Intervention Model for Family Support Services In Low Income Communities, October 20, 1990; FAMILIES FIRST: An Early Intervention Program for Coordinated Family Support Services for Marin City Families, November 30, 1991; and Comprehensive Family Service Systems : A Handbook for Planning and Practice, November 30, 1992.

The following program assumptions were made based on a previous literature review and our early intervention experience:

1. An early intervention program should be designed not as an inoculation but as a first step in a continuing and comprehensive system of supports.

2. Early intervention efforts should take place with and through already existing agencies in the community served rather than stand alone: and in addition to individuals and families, service systems should be the focus of the intervention.

3. Partnerships with schools that will eventually serve program children should be established well before children reach the school door.

4. To maximize educational and social benefits, intervention should be started early with particular attention paid to the development of the fetus in a drug free and healthy womb and to the quality of childcare services provided.

5. Effective early intervention calls for establishing a personal relationship between a member(s) of the early enrichment team and the families served, particularly the principal caregivers of the program children. A case manager, home-based service system is well suited for ensuring the establishment of a personal relationship.

6. A non-judgmental analysis of family strengths and practical needs (i.e., nutrition, childcare, housing, finances) should form the basis of individualized intervention strategies for families. This intervention must include needed therapeutic services.

7. High quality childcare services must be made available to families served.

8. Special attention has to be paid to "life cycle transitions" the family goes through as a child matures.

Twenty five pregnant Marin City residents have been recruited into MCFF in 1993 and are currently being served. It is anticipated that their families will continue to be served until children reach third grade. Twenty-five additional families will be recruited in 1994. Documentation, evaluation, and dissemination of program and family progress as compared to a comparison group will be conducted.

To deal with traditional family support issues and newly emerging ones FWL works in close cooperation with 12 service and educational agencies in Marin City, and in particular with Operation Give a Damn (OGAD), the local agency that houses our programs Family Advocates. A "Program Facilitation Team" of specialists in various areas of family support and community development are being enlisted and interact directly with program and research staff. A regional advisory panel provides advice on program operations and also assists in dissemination of findings to the region.

The common strategy of this project is to integrate the education community with other social service agencies, private organizations, community groups and family members in

planning and conducting comprehensive services for at-risk families. The project provides information and services geared toward helping at-risk children succeed in school.

A key component of the work is weekly family contact. A family advocate works with each of the families, and in collaboration with a clinical coordinator develops appropriate in home interventions and links with community services and community organizations. Additionally, it is the role of the clinical coordinator to augment the work of the family advocate by organizing and orchestrating community service agencies around the particular needs of program families. It is this work that will be described in this document.

II. Marin City Life

Background Information on Marin City

Marin City is an isolated African-American community located in otherwise affluent Marin County. In a county with one of the highest average household incomes in the nation, 36 percent of households in Marin City have incomes below the poverty line. It is estimated that 34 percent of adults are unemployed and that 36 percent of adults have not completed high school. As many as 50 percent of adults may be functionally illiterate, and one study indicated that about 41 percent of all residents lack the basic skills necessary for entry-level jobs. Approximately 75 percent of residents are African American, and almost two-thirds reside in public housing. Eighty-nine percent of families are headed by a single mother. Marin City has high rates of unemployment, particularly among young males; crime, much of which is drug-related; and teenage pregnancy.

The geographical layout of Marin City serves to weaken an already fragile community. In the late 1950's, the commercial center of Marin City was destroyed as part of a redevelopment project, and was never rebuilt. As a result of the same redevelopment action, a 32 acre piece of barren land separates the public housing in a valley called the "Bowl" from the hill where the ownership portion of the community is located. Housing has consisted of government facilities and a few moderate income homes. More recently higher priced homes have been built at the outer perimeter of the community, bringing many white residents into the community but with little or no contact with residents. Approximately 1/3 of the Marin City population lives in the public housing projects. The Bowl Area housing pattern consists of Public Family Housing, Limited Equity Cooperative Housing, and Single Family Housing. As of 1987, there were 292 contiguous low-rise and mid-rise public housing units, 98 units of cooperative housing, and 86 single family homes. The average household income in the public housing units is $8,000, and the monthly rent per unit is approximately $200/month.

Much of the social service support for the community comes from outside Marin City with agencies providing services based on categorical funding. One internal service agency is OGAD (Operation Give A Damn). This local agency often finds itself surprised by initiatives introduced by outside agencies that have been targeted to serve Marin City residents. OGAD administrators cite this outside planning, fragmentation of services, lack of coordination and lack of direct funding of Marin City agencies as major frustrations. In keeping with its facilitation philosophy FWL has teamed with OGAD and other local service agencies in the planning of MCFF.

Current Conditions

Despite the good work OGAD has accomplished in its 25 years of existence, the plight of Marin City children and families is critical. Currently the Marin City community is overwhelmed by drug related issues. Over 80% of families in MCFF are affected by substance abuse and drug dependency; the impact of drug abuse on both pregnancy and family functioning is high. Marin City children today face circumstances that children of other times have not had to struggle with. Indeed, there has always been substance abuse, but the introduction of crack has taken it to an unprecedented level of danger and despair. Children must struggle with the reality of crack use surrounding them, while they are increasingly expected to fend for themselves in a fast-moving society which decreasingly values extended family. The urgency of their situation is heightened by the fact that they still experience racism despite the fact that we are seven years from the twenty-first century.

As a result of these conditions an obvious intended outcome of MCFF is to develop and implement strategies for providing family support to substance abusing families. FWL and OGAD staff are therefore spending a great deal of planning and service time relating to drug prevention and treatment. Collaborating agencies are also exploring ways to find residential treatment for program participants.

III. Marin City Families First Operating Principals

A. Relationship Focused Intervention - The focus of intervention should be the development of supportive relationships, and networks.

To be truly effective community interventions must be planned so they can become part of an orchestrated and ongoing social support system that is part of the daily fabric of community life. Effective interventions should emphasize connection. It is through connection that isolated families, and overwhelmed service providers and agencies can change their fate. One obvious path to a stronger more supportive community is helping children and adults understand the truth of their interdependence with, and reliance on others in their community. MCFF models and supports the development of helping relationships and community connections. This is done through facilitating the development of personal links

among family members, MCFF staff and families, families and other community members, families and social service agencies, and among service agencies at the staff and program level.

This facilitated linkage is a key component of our intervention. It is a programmatic assumption that individuality in our society has gone to destructive extremes. Our quest for independence often leads to loneliness and isolation. For families to have as their goal that each child should have separate toys, separate rooms, separate sleeping arrangements, and sharply defined understandings of me and mine inclines the child to think that separateness is the natural and desirable condition and inclines the child to push for continued separateness as an adult.

A sense of security comes from feeling connected -- a part of something bigger and stronger than self. This is one of the reasons why gangs are so attractive. Right from the start in our dealings with young children MCFF tries to re-balance definitions of identity to include one's connection with others. Like a stone which makes concentric ripples outward when it is dropped in a pond, individual identity starts with self and moves outward to include connections with family, community, society, humans, all life itself, and finally all existence.

This definition of self disinclines people to feelings of isolation and promotes feelings of shared experience. Seeing relationships in this way gives less value to notions of opposition and unchangeable positions and more validity to notions of mutually advantageous relationships and shared connections. Pragmatic life lessons about this new and more accurate understanding of identity are being created as part of the MCFF experience. We share with parents and children:

- The power of varied perspectives
- The importance of relationship to harmonious functioning
- The dependence of life on connections among living things
- The limitations of defining and objectifying any position too concretely
- The incompleteness of non-holistic explanations.

Socially, both children and families need relationships with caring people in which they feel both secure and connected. A sense of isolation is an all too common outcome in low -income communities. Sheila Kamerman has said that if interventions are to be accepted by the families served they all have to have three components which we have incorporated into our relationship focused approach:

Affect - True caring
Affirmation - The acknowledgement of the efforts the families are already taking
Aid - Practical down to earth assistance

B. Community Mental Health - A redefinition of acceptable interpersonal behavior and community esteem needs to be developed.

If one were to look dispassionately at adult functioning in Marin City he or she would be forced to admit that far too many people are struggling through life shackled by feelings of insecurity, fear, and residual anger from the ways they were treated as young children, and are being treated as adults. Far too many people are doubting their own worth, overly afraid of others, and convinced that ruthless individualism, "getting as much as they can for themselves," and aggression are the only legitimate paths to survival and security. Racism, poverty, rough childhoods have led to lives filled with too much suspicion, too much hatred, too much denial of connectedness and common fate. Many family members are living lives that tear their self esteem and optimism.

Much of this unacceptable living climate can be traced back to childhood. One such area is physical abuse and neglect. "A review of research (Graziano and Mills, 1992) found that physically abused children have significant difficulty with aggression and self-control, demonstrate low social sensitivity and empathy, poor cognitive skills and academic performance, depression and other psychopathology, poor social relationships and moral development (Graziano, 1992). It is clear that abuse creates psychological problems. MCFF will work with parents to raise this current generation of children to adulthood to be more emotionally healthy, and wiser than we. Rosemarie Greiner (1983) in a workshop she conducts on peaceful living states that we should aim toward supporting young children so that they have:

- High levels of self awareness
- High levels of awareness of others
- High levels of imagination
- Sound conflict resolution skills
- Love of nature
- Global awareness

But mental health is not just the absence of psychological problems; it is the presence of strong intellectual and emotional capacities and an understanding of the benefits of connections among people. As Graziano (1992) suggests in his article "Why We Should Study Sub-Abusive Violence Against Children", it may be possible to raise the level of adult functioning in future generations by altering in positive ways child rearing practices.

C. Socially and Physically Safe Sanctuaries - In order for parents and families to make long term gains they need to have safe havens in which they can heal and grow.

If we wish to prepare children and families to act in more caring and less violent ways in the fearful realities they now face, we must provide them with sanctuaries to explore new ways of behaving. Everyone needs a secure place to rest and repair. David Hamburg, the President

of Carnegie Corporation, has made the point that, particularly for very young children, this safe haven is necessary. Without, as he calls it, a chance for a prolonged immaturity (protected early years spent with caring adults), children are forced to develop premature rules for the attainment of their safety, security, and survival. When developed early these rules are almost always too rigid, limiting, and too fearfully based. MCFF will work with community members to establish therapeutic nurseries, family resource centers, and high quality child care settings in which trusting relationships can be established so that families and children can have a safe and secure place to grow.

D. Two Pronged Intervention Plan - Both families, and community agencies need to be the focus of the intervention.

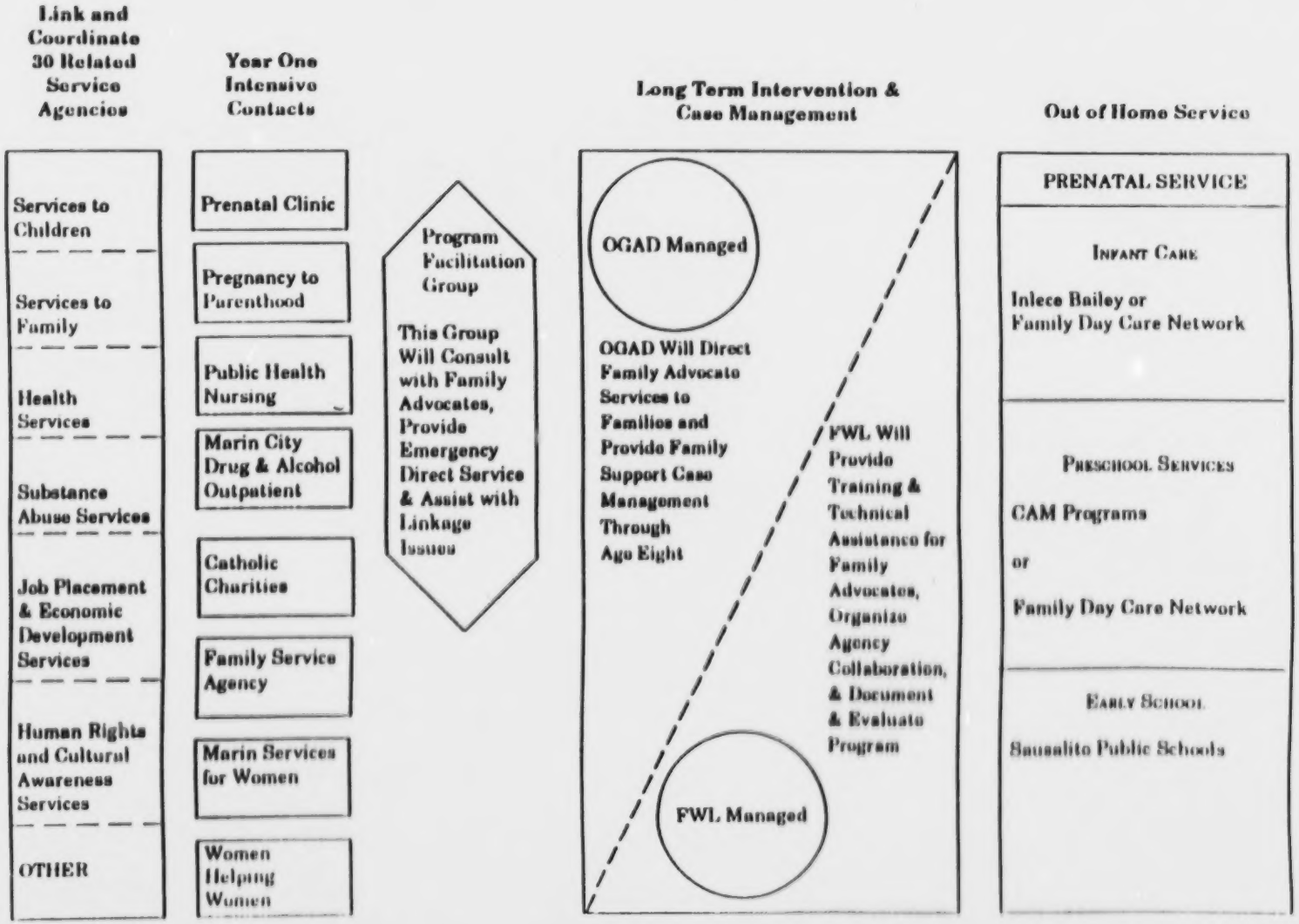
Young children and their families are dramatically affected by conditions and events that take place not only within the home but also within the broader contexts in which family life is embedded. Individual change must be accompanied by contextual change if the changes are to be more than temporary. This means that if an intervention approach focuses on only the home or on only the larger context in which the home is situated, the intervention will be incomplete.

To address this possible intervention shortcoming, a two-pronged intervention strategy has been designed as illustrated in Figure 1. The model provides for direct intervention with families, support to those providers who provide the intervention and direct intervention with agencies. The first prong, **The Augmented Family Advocacy System**, is designed to deal directly with program families, using a case management system to identify and meet individual child and family needs. This aspect of the intervention attends to the particular needs of the family: parent/child relations, other family relations, and to family relationships with the various informal neighborhood and community networks and service agencies they need to deal with to function effectively.

A second prong, the **Community Services Support System**, deals directly with those informal networks and service agencies. It is designed to develop long-term changes in the quality of family life in communities served. Agencies that serve program families are brought into collaborative working agreements with MCFF and participate in the design and implementation of a long-term service strategy for program families. Informal neighborhood and community networks are identified, enlisted, and facilitated in their support of program families. The **Community Services Support System** focuses on upgrading and expanding services as well as establishing and maintaining collaborative relationships among informal networks and service agencies.

Our strategy for work in the area of family transitions can be used as an example of this two pronged approach. It is clear that benefits gained by children and families often get lost as a child and family make a transition from one social or community system to another. When a child moves from care in their home to care in an infant center, to Head Start, and to school,

Figure One
Families First: Long Term Family Support


Link and Coordinate 30 Related Service Agencies
Year One Intensive Contacts
Long Term Intervention & Case Management
Out of Home Service
Services to Children
Services to Family
Health Services
Substance Abuse Services
Job Placement & Economic Development Services
Human Rights and Cultural Awareness Services
OTHER
Prenatal Clinic
Pregnancy to Parenthood
Public Health Nursing
Marin City Drug & Alcohol Outpatient
Catholic Charities
Family Service Agency
Marin Services for Women
Women Helping Women
Program Facilitation Group
This Group Will Consult with Family Advocates, Provide Emergency Direct Service & Assist with Linkage Issues
OGAD Managed
OGAD Will Direct Family Advocate Services to Families and Provide Family Support Case Management Through Age Eight
FWL Will Provide Training & Technical Assistance for Family Advocates, Organize Agency Collaboration, & Document & Evaluate Program
FWL Managed
PRENATAL SERVICE
INFANT CARE
Inlece Bailey or Family Day Care Network
PRESCHOOL SERVICES
CAM Programs
or
Family Day Care Network
EARLY SCHOOL
Sausalito Public Schools

the rules of appropriate action change, as do the rules for the adult family members as they relate to these and all the other social and community systems they must deal with as the child grows. The larger context influences the quality of this social experience and contributes to positive or negative experiences. For minority children, it may mean encountering children from other cultural groups for the first time or it may mean becoming more socially competent in a culturally homogenous context. Either one of these conditions is going to require different adaptations on the part of the children. To influence adaptations in a particular cultural group, it is necessary to influence both the developmental aspect of the transition and the context for the transition. Thus, in this intervention model both individual/familial and system issues are addressed. Direct assistance is provided to the program families through case managed family advocates. At the same time direct assistance is provided to the social and community systems to help them adapt their policies and practices to deal with issues such as "developmental transitions" through the development of a special consultant pool. This is but one of many areas that could be cited as an example of simultaneous intervention into family systems, and social and community systems.

E. Individual Family Plans - Each family must participate in developing their own programmatic goals.

Each family participates in developing a plan which outlines in a direct manner specific areas of concern which will be covered on the home visits and in other activities. Services that the family needs are outlined in this plan and serve as a guide for the families and the family advocate as to their activities. The plan also provides a concrete way in which the family can take credit for accomplishments such as successful entry into a job training program, weaning of a child, or location of a better housing situation. These plans are developed jointly by family members and the family advocate. The development of these plans and strategies for implementation are discussed at case conferences with the clinical coordinator, FWL staff and members of the Program Facilitation Group.

F. Program Facilitation - Effective early intervention cannot be done in isolation.

There needs to be supportive links to advice and assistance for Family Advocates and Case Managers. For that reason a Program Facilitation Group Facilitation Group is seen as an essential component of the work. The Program Facilitation Group supports the project's intervention. Five professionals are selected each year to assist the MCFF effort. They receive a special orientation and are asked to make a 5% commitment to the program. This group provides overall support to the family advocate, consults with coordinating agencies and provides some direct service to families. Each group member will have as a primary responsibility the delivery of advice and programmatic expertise to the family advocate as well as to participating agencies. Each group member is knowledgeable and able to work in a general way with all staff in terms of the overall goals of the program as well as to be able to specialize in a particular area. The role involves regular contact with the family advocate and participation in training, linkage and coordination with community agencies.

Each group member has a particular specialty as well as professional networks and connections to others working in their field. Areas of expertise that are included are: infant/toddler development and mental health, family development and education, community resources, career development/job training, substance abuse, medical and health service delivery, child care programming, community education, and home-based programming. Each year different members of the team will be selected who best meet the needs of the program families and the family advocate.

G. Quality Child Care - Child Care must be made available to families in need.

Based on the study of previous successful early intervention programs it has been concluded that quality child care must be a central part of any early intervention activity. Without the availability of child care many of the parent related services, for example, job training, and drug treatment, cannot be carried out successfully without putting the child in jeopardy. As a primary component of MCFF child care services for program families will be developed using already existing infant and preschool programs housed in Marin City and a Family Day Care Network that will be developed in the first year. The intention of the program is to make child care services available to all MCFF families throughout infancy, toddlerhood and preschool years. It is anticipated that this service, though not mandatory, will be a most attractive program service. The goal of the child care service component is to:

1. provide quality childcare with a consistent program philosophy throughout the first five years of life.

2. allow adult family members to participate in job training, and remedial skills development, and to focus on other personal needs

3. provide a setting for observation of children and the role modeling of appropriate interactions to give parents broader perspectives of their child(ren)

4. provide natural support networks with other parents

5. develop appropriate activities and supportive relationships provided by child care staff

H. Culturally Grounded Experiences - The program should develop from and be part of the community culture.

The following nine recommendations for cultural sensitivity will be followed.

1. *Provide Cultural Consistency*

   Child care and other services should be in harmony with what goes on at home, following the form and style of what is familiar to the child and the family.

2. *Work Toward Representative Staffing*

Employ staff who are of the same culture and who speak the same language as the children and families served. Include culturally representative staff in decision-making positions.

3. *Use the Home Language*

When possible, program staff should speak the language of the children and families served. Written materials should be translated into the home language. If necessary, have a translator available to assist communication.

4. *Make Environments Relevent*

The environment of childcare centers, family resource centers etc. should reflect the culture of the children and the families served. It is especially important that when very young children are in services outside the home they are made to feel at home by bringing symbols (family photos,etc.) of the home into care.

5. *Uncover Your Cultural Beliefs*

All people belong to a culture or cultures and see the world through their own cultural "lenses." One's own values and beliefs influence the type of service one provides. Staff should participate in a supervised process that helps them to uncover their cultural beliefs.

6. *Be Open To the Perspectives of Others*

Staff should be trained in an awareness of multiple perspectives relating to childrearing and family functioning. There is not only one "right" way to do things.

7. *Seek Out Cultural and Family Information*

Staff should learn about the families and their childrearing through reading, asking questions, visiting the community and if parents are willing, discussing these topics with parents.

8. *Clarify Values*

Staff should talk with parents about things that they are unsure about or that cause disagreements and make themselves available for conversations with family members about their concerns and values.

9. *Negotiate Cultural Conflicts*

When there are differences, be open to the families's point of view. Be willing to change some of the program practices based on family feedback.

I. Responsive Facilitation Process - Change must come about with and through the efforts of the families being served and grow from community needs and effort.

For the past twenty years Far West Laboratory has been involved in assisting local communities plan and develop social and educational programs to better serve young children. Over the years a philosophy of assistance has been delineated which we have come to call the Responsive Facilitation Process. At the heart of our approach is the recognition of the need for children and families to experience a continuity of care across educational and social service settings and domains. There are two overarching goals of the Responsive Facilitation Process. The first is to get service providers to accurately understand the needs of families. This is done by assisting and enabling administrators, teachers, service providers, and caregivers to see the day to day life experience of community families and children from the point of view of the children and families. The second goal is to assist and enable these different groups to develop program plans based on this new "family vision", plans that address actual short term needs and plans that provide, in the long term, for the alteration, orchestration, and continuity of currently provided services.

Three basic tenets of the Far West Laboratory facilitation philosophy are:

1. Local norms, names, customs, and traditions should not only be respected but capitalized on to make the program meaningful for the community. The role of the facilitator using the Responsive model is to customize, adapt, and link intervention strategies.

2. Local programs, community action groups, and other key actors should be enlisted in support of the program from its inception.

3. Decision-makers are those who make decisions and act on them. They are found at ll levels of a community system. Therefore, it is important to enlist participation of all participants in a community - administrators, teachers, parents, and other key community members.

Ten specific principles guide FWL facilitation efforts with local communities.

1. Introduce new ideas. The facilitator provides information from other communities and programs that have been successful in providing services to families and children or show promise in doing so.

2. Assist with the development of priorities. The facilitator helps the community define priorities and participates in the periodic assessment and reshaping of priorities.

3. Provide options. The facilitator offers suggestions from which the community members (educators, other service providers, and parents) may choose.

4. Provide training and technical assistance. The facilitators provides technical support that is requested by the community.

5. Stimulate dialogue. The facilitator creates a non-threatening environment that allows for dialogue among the various actors on site.

6. Be flexible. The facilitator takes a flexible approach to change while maintaining a consistent facilitation philosophy and being sensitive to the strengths and characteristics of the local community.

7. Keep low visibility. The facilitator shares ownership for ideas and encourages key groups to assume leadership in creating the program.

8. Provide insight about the big picture. The facilitator should be able to take a stance outside the day to day activities for the purpose of analyzing the community's efforts to attain long range goals and helping the community identify potential barriers.

9. Give moral support. The facilitator affirms community members' efforts so they can carry out their work with the confidence that they are moving in the right direction.

10. Share research and evaluation findings and strategies from similar efforts. The facilitator identifies models and strategies that will assist the community in its documentation of a) program implementation, and b) program outcomes.

IV. Case Management Staff Roles and Responsibilities

Program Direction

The director of OGAD and the program implementation director from FWL ensure that the program's operations are consistent with the mission and purpose of MCFF and are of sufficient quality to meet the program's objectives. As stated earlier MCFF is guided by a two pronged thrust. The first prong emphasizes Family Case Management and the second prong focuses on Community Services Case Conferences. The director of OGAD directly supervises the work of the Clinical Coordinator and Family Advocate and supervises work in both intervention prongs. She teams with the implementation director of FWL to ensure that:

1. Each program family has a well developed Individual Family Plan.

2. Special emphasis is given in the Individual Family Plan to developing a strong teen parenting and drug treatment component of MCFF.

3. Regular Community Case Conferences are provided with the multiple service agencies impacting the MCFF Project participants, to ensure collaboration and coordination of services.

4. Special emphasis is given to developing strong links between MCFF and economic development activities so that families will have access to jobs and job training activities currently being developed in Marin City.

The Family Advocate

After an initial assessment of the families, conducted with the Clinical Coordinator, the Family Advocate meets with families to case manage each families plan. She also assists the Clinical Coordinator to present cases to the community service agencies. The Family Advocate delivers parenting and child development information and has a specific and direct role as a broker of available family services. He/she identifies family needs and the agencies that might best provide services to meet these needs. The Family Advocate also assists families by encouraging successful approaches to obtain needed services. The Family Advocate is the key staff member in MCFF; this home visitor has a multifaceted role. During the home visits, and in other contacts, the Family Advocate assess and clarifies family needs in response to observations, parent sharing, behavioral cues and specific situations that arise. These areas are noted and the content of future visits is adjusted accordingly. Content changes are discussed with the Clinical Coordinator during their weekly case analysis meetings.

The Family Advocates extended role consists of:

a) Delivering parenting and child development information
b) Helping families assess needs and providing linkage with other services
c) Assist in identifying and building relationships with community service agencies
d) Coordinate the work of community service agencies for the program families
e) Design approaches and strategies for agency collaborations
f) Work with members of the Project Facilitation Group to meet family needs
g) Receive supervision from OGAD and FWL training and evaluation team
h) Meet weekly with Clinical Coordinator for case conference on each case, assist in data management & participate in inservice training.
i) Meet weekly with FF management team
j) Participate in OGAD based weekly treatment team clinical meetings.
k) Develop knowledge of all collaborating social service agencies staff, goals and policies.
l) Collect information about the effective functioning of agencies in the community.
m) Make home visits at least once per week per family for at least an hours duration.

Her specific home visit tasks are to:

a) Develop rapport
b) Develop family plan, using topic areas presented in training.
c) Collect family data.
d) Help families identify needs, questions and concerns
e) Conduct family interview.
f) Assess needs of child and family which may or may not be congruent with the families own concerns
g) Link families with obviously needed social services.
h) Link families with child care.
i) Share parenting and child development information.
j) Process data collected.
k) Work with members of the Program Facilitation Group to meet individual family needs family needs

Clinical Coordinator

In selecting the Clinical Coordinator, we thought it was important to identify someone who had a good grasp of clinical as well as social service expertise. The ideal candidate would be familiar with, and sensitive to the community served. The candidate should have a good grasp of the function of case management in a community with a large number of depressed residents and service providers. In addition, a male was sought to assist with the males (father, grandfathers, significant others, children) in the program families. It was also almost mandatory to have a Clinical Coordinator who was African American or at least familiar with the African American culture since the majority of the program participants would be African American. Also helpful was to have a Clinical Coordinator who was familiar with internal and external community resources, the politics of the county, and local funding sources.

The Clinical Coordinator is designated as the primary resource person to the family advocate/s. The assignment involves periodic contact with clients of MCFF. It also includes the conduct and supervision of inservice training for the Family Advocate. A key responsibility is the linkage of MCFF work with the work of other agencies and institutions serving Marin City.

It is expected that the Clinical Coordinator will have skills in Clinical Case Management; have well developed time management skills and experience in handling a variety of roles; be knowledgeable about intervention programs, staff dynamics, and child and family development; have had experience supervising and training social service staff; and have worked collaboratively with a variety of agencies.

Each week the Clinical Coordinator is to meet with the Family Advocate/s to discuss progress, analyze actions and develop intervention strategy. These supervisory meetings will also be used as the vehicle for deciding which collaborating agencies and members of the Program

Facilitation Group should be linked for the purpose of serving individual families.

The Clinical Coordinator's responsibilities:

Case Management

1. Conduct initial assessment of children and each family member in the home with the Family Advocate and develop with Family Advocate an initial intervention strategy.

2. Assignment of families to specific Family Advocate.

3. Conduct weekly reviews of all case records and contacts.

4. Develop with Family Advocate and family members, the Individual Family Service Plan.

5. Weekly meetings with each family advocate in which assigned cases are reviewed and specific intervention steps are planned. A family assessment, and individual service plans will be used as guide in this process. Crisis management techniques and strategy development for presenting problems will take place.

6. The maintenance of contact with other social service and educational agencies that are involved with the family directly or through the Family Advocate.

7. Periodic update of individual service plans and assessment data.

Inservice Supervision & Training

1. Provide ongoing support to Family Advocate

2. Organize and facilitate weekly inservice meeting for Family Advocate

3. Assist Family Advocate in developing monthly Community Case Conference

4. Develop inservice training content pertinent to the needs of the families, family advocates and collaborating agencies.

5. Coordinate the work of the Program Facilitation team.

Agency Linkage

1. Assist in identifying and building relationships with community agencies and other resources.

2. Facilitate community case conferences for a specific family who is involved with multiple agencies for the purpose of coordination of services. These conferences will also have as a secondary purpose the building of linkages and effective working relationships with participating agencies. These community case conferences will be seen by the Clinical Coordinator as useful in providing indirect training in supportive family and child development work in each community.

V. Staff Development

The preservice and inservice training of the Clinical Coordinator and the FAs reflect the three basic tenants of Far West Laboratory facilitation philosophy and the operating principles of the MCFF Project. Trainings center on the following topics:

1. assisting the trainees in becoming familiar with, identifying, and assessing family needs,
2. information on child development and parenting
3. how to link families with appropriate services with an emphasis on moving families from dependency to self sufficiency.
4. strategies to assist in getting the optimal use of the Program Facilitation Group
5. illustrations of how empathy, the authentic presentation of self, and a non- judgmental approach in working with clients are important elements in relationship building with families.

The following orientation and training schedule was used. It is presented as an example for those planning trainings.

Figure 2

Marin City Families First
Case Management Orientation and Training Plan

1. Orientation Activities

   a) Overview meetings to discuss:

   - History of MCFF
   - Link with strategies used in Syracuse Family Development Research Program
   - What MCFF is
   - What MCFF isn't

- Critical Issues related to Implementation
- Overview of Evaluation Plan
- Job Descriptions
- Lines of Authority

b) Independent Reading

- MCFF Proposal
- Augmented Family Advocacy System
- Evaluation Plan

- Syracuse Family Development Research Program
- Job Descriptions

c) Links with collaborating agencies

- Desires/Needs of Collaborating Agencies
- Critical Issues Related to Implementation of collaboration
- MCFF links to Marin City Long Range Plan
- Building a transdisciplinary system through use of a case conference strategy with collaborating agencies

d) One on One Orientation meetings with Collaborating Agencies

- Learn services
- Discuss FF role and collaboration

e) Visits by Family Advocate & Clinical Coordinator to Collaborating Agencies

2. Training Activities

a) Baseline Data Collection Responsibilities

- Family Interview
- Use of Management Information System
- Collection of Community/Agency Functioning Data
- Collection and use of information from collaborating agencies
- Recruitment of program families and comparison families

b) Training on the Development and Use of the Family Plan

c) Training on appropriate parenting and care of infants and toddlers

- Use videos and curriculum guides from the Program for Infant/Toddler Caregivers
- Onsite work with supervision at Ineice Bailey Infant Center

d) Training in social work component of home visitation

e) Training in Self Sufficiency vs Codependency approach

- Individual consultation
- OGAD Treatment Team Clinical Meetings

Clinical Supervision and Training of Family Advocates

The goal of clinical supervision and training in the MCFF program is to provide a supportive environment in which the FA can feel free to experiment, to acknowledge successes and failures, to risk and become empowered to struggle with the complex task of work with the program families.

The task of supervision and training is therefore a gradual empowering of the FAs that is brought about by helping them to:

1. feel more confident in their ability to advocate and provide appropriate services to program families.

2. Understand their own cultural values and family background.

3. Learn about the culture of the families they work with and,

4. Provide a theoretical framework within which they can view their work.

It is important to emphasize the central role of support and encouragement in this process, because there is a definite relationship between the support the FAs receives from their supervisor and the support they provide to families. The key to accomplishing this task is the establishment of positive relationships with the FA by using a model that depicts the role of supervisor as consultant rather than one of authority.

A problem solving approach is used to teach the FA to use the process of problem assessment and solution as a "road map" for developing and implementing family plans. The supervisor facilitates this process by helping the FA to stay focused on problems to be solved and to identify the most important issues which need interventions. The case of Alpha, which will be presented in detail later in this document can be used to illustrate several of the supervisory strategies used in the MCFF program.

> *The goal in working with the FA on the Alpha case was to allow her the opportunity to trust her instincts based on the relationship she had established*

with Alpha. In problem-solving with the FA around developing a plan of action to work with Alpha it was decided to maximize and use the existing and developing relationship the FA had with the staff of the community based program that referred Alpha to MCFF. As a result of this approach the FA was able to continue to build a relationship with Alpha, in spite of the fact that she was incarcerated. Secondly, a major learning experience for the FA came from working with several other agencies in a collaborative capacity. By building on the relationship she had with the Maternity Service and the Marin City Drug and Alcohol Program the FA was able to develop a plan along with these agencies in terms of approaching the court on Alphas behalf. This approach resulted in Alpha being allowed to enroll in a residential treatment program rather than continuing with her incarceration. Alpha's failure at a residential treatment program afforded the opportunity to educate the FA on certain aspects of drug treatment philosophy. Part of that philosophy clearly indicates that relapse is a major part of recovery.

The second supervisory activity in this case was to indicate the importance of the FA approached the client after this failure in a non-judgmental way, and again began to engage in a problem-solving endeavor which allowed the client and the FA to reconnect and restructure the family plan. This reconnection took a period of time. The FA had to convince the client that there were other opportunities for recovery in different programs; and that this recovery could be facilitated by the FA It was important to help the FA stay in touch and continue to approach the client in a non-judgmental way and let the client know through various ways that she was not going to abandon her, and would be there to support her in whatever decision she made in the next step of her recovery.

As a result of the above strategies, the FA in this case has developed a real sense of confidence in her ability to advocate for her clients, and also to be able to look at her own reactions to clients behavior and still maintain a positive working relationship. The progress made by the FA in this particular case was a direct result of the work done in supervisory sessions.

VI. Recruiting and Selecting Participating Families

Any women who lived in Marin City and was pregnant but not past her sixth month of pregnancy by February 1993 was recruited into the MCFF program.

The recruitment approach most effectively used in MCFF was based on our relationship approach to intervention. A key example of the strength of relationship was how it helped with the admission of families to our program. It was the pre-existing relationship of MCFF service providers with other service providers in other agencies that enabled us to meet and

recruit families into MCFF. Initial contacts were made, when possible, through already existing service providers that had already established a sense of trust with clients. Our entree was facilitated most effectively by our program and staff being introduced to the family by an already trusted service provider. This technique allowed for start up activities to proceed at a faster rate than for the recruitment efforts that were not facilitated by someone already in relationship with the clients. In fact, after seven months of operation, our deepest program/client relationships are those established through facilitated recruitment.

The relationship with the families of Families First began after the referrals were made. The referring service provider encouraged the client to get involved with Families First, and explained the benefits of doing so.

VII. Building Relationships with the Families

As with recruitment, preparation for the initial visit was done in conjunction with other trusted service providers. It included a review of information such as tips about client's attitude, drug use, and family constellation that might influence the content and scope of the initial interview. General goals for the initial visit were:

- to began to establish the provider/client relationship, and
- to explore the client's views on his or her current life situation.

The initial visit frequently revealed specific issues requiring immediate assistance. These issues became part of the short range family plan. Services quickly rendered afforded an opportunity for MCFF to produce practical and family sensitive results as a way of demonstrating usefulness to the client. They also allowed the client to test the honesty, consideration, and competence of the Family Advocate and the MCFF program. Part of providing initial emergency assistance was an analysis by the Family Advocate of how a particular client's family functioned in a problem solving mode. This information is important in determining the way the family plan was formulated.

One case demonstrating effective relationship building follows:

> *Alpha was incarcerated at the time of our initial recruitment. She was referred to MCFF by an outreach worker from a community-based service agency. The outreach worker was positive in her description of MCFF and the character of the Family Advocate. This created the first link between client and MCFF. Since this client was not easily available to the FA, because of her incarceration, it was crucial that opportunities for contact be maximized. Because of connections with the outreach worker and staff at the penal institution MCFF, FA was notified of prenatal care clinic visits of the client. The assistance of the*

outreach worker in convincing the accompanying sheriff of the importance of Families First contact made possible the allowance of extra time for the clinic visit so that the client could meet with the FA. This contact proved crucial. The FA was able to help the client to build a case to be released from the Honor Farm to enter a drug treatment program. The client stayed in contact with the FA by phone and in collaboration with Maternity Service, and the Marin City Drug & Alcohol Outpatient Program's staff the FA requested in court that the client enter a treatment center for women, which the court agreed to and where the client now resides. However, this client's recovery attempt led her through more difficulties. She did very well in the residential program for a couple weeks but then left the program.

Though she went back to the drug life and worked hard to avoid the sheriffs in town who know her and know that there was a bench warrant out for her arrest because of her violating the conditions of her release from jail, she maintained contact with the FA and was adamant that she not be discontinued as a client.

Just before she delivered her son, she was beginning to talk of getting into a program again. When the baby was born he was cocaine positive and CPS was alerted. The client was required by CPS to enter a residential program before she could have custody of the baby. She entered a perinatal residential program in San Francisco which allowed her to have her son with her in the program after she had established some routine in the house. Through all of this the client had a very clear and consistent picture of the FA and MCFF as allies who would remain available to promote her and her child's health and growth. A trusting relationship had been established.

Though the client did make attempts to have the FA collude with her in some dishonesty with the treatment programs, she found that the FA maintained honesty even when it got the client "in trouble." She was reassured consistently that the FA cares about her but would not lie to her or to authorities. The client has found competence and reliability in the program and even though she took some detours along the way the relationship with the FA provided some grounding and was a lifeline when times were bleak.

VIII. Implementing the Family Plan

Effectively implementing the family plan is based on two important principles 1) effectively using the relationship that has been established with the client which is based on honesty, consideration, and competency, 2) developing a plan that reflects the participation of the client and the family advocate.

The Family Plan is a tool that is used to identify particular issues to be worked on to strengthen the family system. Some of the strength of this tool relies on the development of the relationship between FA and client. As safety develops in the relationship the client can become more honest and frank about problems within the family and a more comprehensive and wholistic family plan is possible. The Family Plan also is a means of illustrating to the client all the resources for support available to them as they work to reach their goals. Identification of such resource helps the client realize that they are not as isolated as they might feel.

The following case demonstrates the development of a family plan.

> *Beta was introduced to FF by her sister who has worked as a professional service provider in the community and has a good relationship with the FA. Beta is a drug addict but is experienced enough to know how to avoid positive tox screen at delivery. Her fourth child who is a FF focus client was born without any drugs in her system even though there was much exposure during pregnancy. She came home with the baby and picked up the drug life again, drawing concern from friends and family. After a few visits, specific areas of concern became apparent to the FA. This client was not willing to consider that her drug use is problematic but the particulars of how her life is affected by drug use had become clearer. After indications that her extended family wanted to offer support, a family meeting was facilitated by FF to focus on these concerns. At first the client felt under attack but as the meeting progressed, she began to see it as supportive and became more participatory in discussing her hopes. In this context her family plan began development. As she talked about what she wants for her family, these goals were identified for her family plan. The tasks that will lead to their accomplishment and the support persons available to her were discussed there in the meeting. Later the FA and the client got together to review and finalize the plan. It will be updated every month.*

In some cases, implementing the Family Plan has gone very smoothly. Based on the client's motivation and past and current successes and facilitated by the experience of the deepening usefulness of the relationship with the FA, some cases have shown steady growth and progress. An example of this can be found in the following case.

> *Delta has a history of substance abuse which led to CPS intervention after her husband went into recovery and reported his wife for neglect. The children were removed from her custody and placed with him. When Delta delivered her third child she was born cocaine positive and so CPS did not allow the mother to take the baby home from the hospital. She was required to enter residential treatment in order to regain custody of the infant as well as the older two children. The infant was able to join her mother in residential treatment at the beginning of her treatment. The FA provided some intensive support at*

entry into the treatment program and with initial contacts with CPS staff. As the client stabilized in treatment, regular weekly visits were established with FF that reinforced her participation in the other interventions.

The success of this client in drug treatment program was also greatly influenced by an experience that the FA facilitated. Another FF client was already in treatment at this residential program. She left the program after having difficulties with the rules and then when it was too late for her to salvage her chances of continuing in treatment, she knew she had made a big mistake by leaving. The first day or two after she left she had some clarity about her actions. With the assistance of the FA she shared, very effectively, with Delta who had just entered the residential treatment program. "Whatever you do, don't leave the program!" she cautioned Delta, through desperate and heartfelt tears. "It's not worth it." As the FA worked with Delta in the following weeks that image and those words came up as reminder over and over again; the pain of leaving the program is greater than that of dealing with some strict rules and authority figures who you might feel are too rigid.

Part of Delta's Family Plan was to complete residential treatment. She did so and also accomplished other goals included on the Plan. She reconciled with her husband. She worked through a major issue with him involving the paternity of the newborn. The couple entered and continue in counseling together. She satisfied CPS requirements so her children were restored to her custody. She continues in day treatment while keeping a routine with her children at home and in childcare and preschool. She and her husband are strategizing and working together to obtain their own housing so that they will be able to move out of his mother's home soon.

We believe that the above case went smoothly because of the level of motivation of the mother coupled with the sense that by working with a supportive advocate that a continued possibility for growth is present. Other cases, however, do not go so well. Many obstacles arise. An attitude of denial about family circumstances and personal issues such as substance abuse often impedes progress. Extended family systems and friends may enable the client to continue to fail as they compensate by continually picking up the pieces. Often clients facing primary survival issues about food and shelter are not able to deal with more than one issue at a time. Whatever is the most urgent crisis at the time is the issue that receives attention. For example, getting the newborn baby's birth certificate to the AFDC social worker on the last date allowable so as to avoid reduction in the AFDC grant takes such emotional energy that not much else gets done for a while before or after.

One such difficult case is that of Gamma.

Even though Gamma, a young mother has had a history of crack abuse and use in the company of certain family members who have then told others in the

family, and even though she had one positive-for-cocaine tox screen during pregnancy, and even though she was stopped by the Highway Patrol for drunk driving with her two youngest children in the car, she continues to believe that drugs are not a problem for her or her children. Though her grandmother will admit to Gamma's need to get her life together she has a pattern of repeatedly rescuing Gamma -- loaning her money and feeding the family after Gamma spends large sums of money on drugs and month after month mismanages her money. Family and friends come to her home to get the children ready and off to school on time.

Gamma has difficulties with following through on any number of her self-defined goals. For example, Gamma defined two specific goals, getting her third child into preschool, and entering a GED program. Gamma asked for help from the FA with these matters and then missed a number of home visit meetings. When a meeting was held a more pressing crisis took her focus away from her enrollment wishes. With the FA's help Gamma completed the preschool application except for the pediatrician's health report and the GED forms except for a needed confirmation of enrollment. After two months of missed meetings and other crises Gamma had not managed to get the child to the pediatrician to complete the physical exam for the application packet and she had not gone to any of a number of weekly meetings with the GED instructor to have the confirmation of enrollment completed. Gamma represents a type of client that calls for special treatment and case strategy. Her case exemplifies the need for augmented support for Family Advocates. This case is being reviewed by the clinical coordinator for the purpose of bringing in members of the Program Facilitation Team to assist the FA with the case.

Many times a family plan cannot be developed in isolation of other needed services. It has become clear that males play a central role in the lives of these expectant or new mothers even though they are often absent from contact with Family First staff. As an adjunct to a number of family plans it has been decided that the developing of a men's group that will be made up of the fathers and stepfathers of the program families should be attempted. These men are often very much a part of the goals that mothers describe. They are often a source of stability for the young ones when mothers are floundering and sometimes stand in the way of a mother's treatment program. FAs interact with men in the program families as much as possible. One home visit found the FA mediating a family dispute and providing some counseling assistance to one couple. Another father was provided assistance and support about finding housing for his family. It is felt, however, that a more systematic and comprehensive means of strengthening and developing these contacts will greatly enhance family functioning. A men's group facilitated by the FF Clinical Coordinator, who is also a man, is being planned.

IX. Dealing with Crisis

It has been our experience that there are two levels of crisis affecting our families: 1) the day to day issues of survival such as safety, food and finances, and 2) the overall effects of substance abuse and how this impacts children, adults and the environment in which these families live. Again it is important in approaching crisis resolution to be mindful of the need to respect the rights, safety, and dignity of the families that we work with.

When crisis presents itself in a case it can be instrumental in building trust and safety in the relationship between client and FA much more quickly than usual. An example involves Kappa. This young woman has had knowledge of FF for about 6 months before she herself became a client because of her sister-in-law's involvement.

> *Kappa is very quiet and, though she and the FA exchanged greetings when they saw each other, she did not reveal her pregnancy until she was well into her second trimester. She had her sister-in-law tell the FA of her pregnancy. Kappa and the FA scheduled a meeting for the following week. In the meantime a crisis had been brewing in Kappa's life. The father of her two children and of the baby she is carrying has been raping her regularly for about 4 years; these rapes occur at night when Kappa is asleep. The father has said to Kappa that he thought she was awake but Kappa maintains that she is always in a deep sleep when he begins and then when she wakes to his actions she remains very passive in order to avoid angering him and getting hurt more seriously. After these incidents which have been occurring about once a week, Kappa is sore for about 3 days. The weekend before one of Kappa's and the FA's appointment another such rape occurred. Kappa had further worries because she suspected that the father may also be molesting their three-year-old daughter. The following week Kappa came to the offices of MCFF and met with her FA and a service worker from a local maternity services program. She told the whole story of her abuse and reported her observations of her daughter that made her suspect incest. The maternity services outreach worker spoke at length with Kappa and mediated Kappa's report to CPS about the possible incest. The FA's interview with Kappa that day included discussion of the abuse and possible incest and these issues remained the primary topics of discussion as Kappa and the FA continued to develop the client/professional relationship in the days and weeks following. The FA became the primary support for Kappa in dealing with CPS about the investigation of the possible incest. It was about 2 weeks between the time of the report and the first call from a CPS about scheduling a meeting with the child and mother. Kappa was anxious for the assessment to occur and the FA called several times to find out why there was a delay. Finally, the meeting was scheduled and the FA accompanied Kappa and the three-year-old to the meeting. The next day the child was examined by a pediatrician with expertise about injuries resulting from sexual*

abuse. The incest was not proven but the little one did disclose some incidents involving Kappa's sister-in-law's children who are 4 and 7.

This news brought relief as well as a new dilemma for Kappa to deal with. With the conviction that it was not the father of the child committing the abuse upon her three-year-old Kappa felt clearer about how to proceed. She had already let the father know that he could no longer stay at her home nights. That eliminated the possibility of the rape incidents occurring. However, a new crisis presented itself with the information about the sister-in-law's children -- how to share this information in a constructive way, how the children's interactions might need to change, and how to maintain the family relationships through this crisis.

During all this time the FA provided much support. Early on as Kappa told her story, she did not say much about how she felt. The FA was able to offer validation for feelings that Kappa was having without Kappa feeling forced to talk. When tears came, the FA acknowledged Kappa's need to have space to finally let them flow. As the FA acknowledged Kappa's courage and persistence, Kappa would offer some explanation about just how she was courageous and persistent. As the FA appreciated Kappa's modelling for other parents, Kappa seemed flattered, but questioned the idea. When the FA pointed out the reasons why she is a good model, she beamed and shyly agreed it was true. The FA discussed the need for community-wide education about child sexual abuse for adults as well as children. When she suggested that Kappa be involved in planning these events she was enthused and willing. Kappa and the FA strategized about how to approach the sister-in-law in a way that would be constructive.

X. Sustaining Relationships

Sustaining relationships with program families depends on the FA continuing to be empathetic, honest, and non-judgmental in working towards implementing the family plan and keeping it a high level of trust. This is particularly important in dealing with the issues facing many MCFF families, such as abuse and neglect, which might require legal intervention by agencies such as Child Protective Services.

Sustaining relationships with clients is very dependent upon the success with which the FA communicates herself to be honest and trustworthy from the beginning of the relationship and then continues to demonstrate these qualities to the client. The FA must be a real person to the client. She must be willing to be self-disclosing and open about who she is while maintaining a sense of professionalism and authority. She must not seem to be someone that holds herself above the client even though she may have achieved more. The FA must model

behaviors and successes to the client while avoiding an attitude of 'I made it, why can't you?' The FA must avoid manipulation as this can do much to destroy trust. The FA must be honest about her thoughts and expectations and about her interventions and advocacies. The FA must take care in the part she plays in the development of the family plan -- to hold out expectations to the client that are attainable but not so great that the client is set up for failure. The FA must routinely and genuinely offer encouragement and validation for successes that do occur.

With these qualities in place obstacles still surface. There can be difficulty in keeping regular appointments; clients may not even own a calendar or think in terms of plans for the week ahead. The client may not be home when visits are attempted. The client may not be awake, dressed or willing and ready to answer the door, even if a meeting was agreed to or suggested by the client the day before. Confidentiality is always a big issue. The FA must be clear about what she will and will not share and what she must share. Furthermore, worries about how the FA and MCFF may be interacting with other service agencies that are not trusted by the client can affect willingness of the clients to engage in MCFF activities. The following case illustrates the sustaining of relationship.

> *Chi is the mother of 8 children. Five are living in the home and four are under 5 years of age. Two of the children not living in the home were permanently removed by CPS after a report made to them about their treatment by another agency that serves the community. Chi has been a repeated client of the Marin City social service delivery system and has great distrust of people becoming involved in her and her family's lives. After initially refusing involvement, Chi agreed to participation in MCFF. This was done initially because of grave health difficulties she had during pregnancy. However, Chi developed a liking for the FA who developed an easy and quick rapport with the children in the home when Chi would not interact much. The FA provided some immediate advocacy that was very supportive of the family. The FA also offered some cultural sensitivity and understanding when she accompanied Chi to a mediation with a white service provider from the county social service department that made mediations quite effective. These positive experiences were part of building the trust and safety that allowed Chi to come to the FA with news of some sexual play and exploitation of and among children in the community that also involved her 3 and 4 year olds. Chi had very sensitive and appropriate responses to her children and asked for help in using the incident as a springboard for intervention about this issue for the community. She also went with a group of parents whose children had been involved in the incident to the pastor of the church that one of the older children attends. The FA encouraged her in her efforts and MCFF is working with her in developing a community forum to provide education and support to both parents and children in Marin City.*
>
> *Despite the trust that had developed between Chi and the FA a significant difficulty arose. When Chi and the other parents met with the pastor, also in*

attendance was a relative of the pastor who happens to be a therapist working in the community. He let parents know that he had to file a report with CPS. Though Chi was clear that the FA did not make this report, she began avoiding the FA. She would agree to meetings and then not be home at the appointed time. She would be on her way out the door or busy with other things when unannounced visits happened. However, after a time of playing cat and mouse, Chi finally approached the FA and said, "You know I'm ducking you," with a laugh and sparkle in her eye. The FA responded in kind with humor and an assurance that she wasn't going to give up. The FA validated Chi's perceptions that "whenever I let you people (service providers) in my business I got CPS at my door." Chi then invited the FA to a meeting about the Individual Educational Plan for her 4 year old.

XI. Next Steps

MCFF is in its infancy. But we have already learned many valuable lessons. It has become quite clear that family support efforts in the 1990s have to be quite different from those of the sixties and seventies from which we take our guidance. Drug treatment services have become crucial. Safe havens from violence, drug use, and abuse for children and families have become necessary. Child care must be provided that meets not only the needs of families to pursue treatment, training, or employment, but be of a high enough quality to serve and treat children who have special needs brought about by problematic community or family conditions.

It has become clear that no one agency or institution can provide all the necessary services or wisdom to meet the needs of the families we serve. We have concluded that we must develop strategies to empower community members to take on and solve their own problems. We plan to focus much of our efforts in the coming years on developing leadership in the community, leadership that can take on community problems, such as the problem with inappropriate childhood sexuality presented in the Kappa case that Kappa is beginning to take on with our assistance.

Over the next few years new strategies will be developed to create more effective community resources, such as helping to get a Narcotics Anonymous group started in the community, and helping local churches find funding to provide quality child care. We hope that what we learn will be a part of a success story in Marin City. Whatever the outcome we will document our efforts and share our experiences.

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